# SERVICES FOR THE MENTALLY ILL INMATE:

# AN EXPLORATORY INQUIRY

## Selected Issues at the Interface of the

## Mental Health Service And Criminal Justice Systems

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# EXECUTIVE SUMMARY

# OF

# "SERVICES FOR THE MENTALLY ILL INMATE: AN EXPLORATORY INQUIRY"

## I. BACKGROUND

A. Introduction: An individual who is mentally ill may for one reason or another end up in jail or prison. What services are available to identify and treat mental illnesses among these inmates? What is the prevalence of mental disorder among prisoners? What issues and problems arise at the interface of the mental health and criminal justice systems related to services for the mentally ill inmate (MII)? Which agencies - mental health or corrections - should be responsible for attacking these problems and issues? This paper draws together some of the empirical research which bears on these questions. It also identifies key policy issues worth pursuing further in the future.

B. Focus: The paper focuses on services for the adult mentally ill inmate (MII), whether recognized or diagnosed or not, in jails and prisons at the state and local levels. This group has been largely neglected in past discussions of "the law and mental health" and related topics. A partially overlapping group consists of the "mentally disordered offender" (MDO). The MDO is identified and adjudicated (formally designated) mentally ill before being sentenced and is usually diverted to a secure treatment facility. This

group of offenders includes those incompetent to stand trial, the guilty but mentally ill, those not guilty by reason of insanity, and those judged so dangerous and disturbed that they require immediate evaluation and treatment. In contrast to the mentally disordered offender, the focus of this paper is on the sentenced and incarcerated inmate "doing time" who has a mental disorder or illness.

C. Caveats: There are some overlaps and interactions between the practices and processes related to the mentally ill inmate (MII) and the mentally disordered offender (MDO). The evidence on the prevalence of disorders and about services for the MII is now only partial and uneven. Because the problem area is embedded in society's response to crime, punishment, freedom and justice, it is saturated with our deepest individual, social and cultural values which makes it "treacherous."

## II. CONTEXT OF THE PROBLEM

There are three primary institutional locales of the mentally ill inmate (MII): jails, prisons and secure treatment facilities.

A. Jails numbered about 3,336 in the U.S. in 1983. They range in size from one to two-person rural jails to large urban complexes with 5,000 or more inmates. In mid-1984 there were an estimated 231,000 persons in local jails. Adult admissions and releases for the year totaled over 15 million.

Evidence suggests that the prevalence of severe mental disorders among jail inmates ranges from 1 to 7 percent. The rate for less severe forms ranges up to 20 percent. Teplin found that estimated lifetime prevalence rates for severe disorders was higher than in the general population; e.g., the jail schizophrenia rate was 3.3 percent compared to 0.9% in the general population. Others have concluded that jail inmates rates are no higher than those of a class-matched normal population.

Jails are normally small, short-term detention facilities run by local governments with a high inmate turnover. They experience high rates of suicide, especially among young, first offenders. They have also been a relatively common holding location for some of the deinstitutionalized mentally ill homeless.

## III. PRINCIPLES FOR JAIL PROGRAMS

Steadman et al. (1986) examined over 40 jails and derived a set of five principles intended to guide the planning of "humane and responsive" jail mental health programs. In brief summary, the mentally disturbed jail inmate must be viewed as a community issue; the jail should remain primarily a correctional facility and not a mental health clinic; jails need limited but high quality professional mental health services; the areas of identification, crisis intervention, and case management should be stressed;

and "there is no one best way to organize" a jail mental health program.

## IV. THE SECOND CONTEXT OF THE PROBLEM: STATE PRISONS

A. Prison Characteristics: There were about 430,000 prison inmates at the end of 1984. Of 791 correctional facilities (there are now about 903) 568 were classified as "confinement facilities" and 109 were maximum security. In 1986 state facilities were at least 6 percent over capacity. Overcrowding was widespread. Prison sentences range from a minimum average of 4.3 years to a maximum average of 8.6 years. Most prisoners are released early.

B. Prevalence of Mental Illness in Prisons: In a survey conducted by the New York State Department of Correctional Services in 1983 roughly 24,000 inmates (about 6% of the total 400,000 inmate population) in 48 states were officially classified as mentally ill. Most departments of corrections "never" have prior custody of those "adjudicated mentally ill." But some of the "guilty but mentally ill" and "abnormal offenders" (like sexual psychopaths) do show up in general prison populations. Collins and Schlenger (1983) estimated the life-time prevalence of psychiatric disorder by diagnostic category among 1,149 male felons at the time they were admitted to North Carolina prisons. They found a higher than normal prevalence of anti-social personality, alcohol abuse/dependence and substance abuse/dependence. Professionals in the New York State Office of Mental Health recently

surveyed 3,684 of the 36,000 inmates in New York prisons in mid-1986. They estimated that 8 percent of the total inmates showed "severe psychiatric and/or functional disabilities" while another 16 percent showed "significant psychiatric and/or functional disabilities."

## V. CORRECTIONS FACILITIES FOR THE MII

A 1983 survey conducted by the New York State Department of Correctional Services revealed these findings.

A. Identifying the MII: Most MII have not been identified as such by the courts before imprisonment. Correctional departments vary in the scope and depth of their screening and identification processes. In 17 departments a psychologist conducts intake interviews. In another 12 it is the "psychology staff" while a wide range of others are involved in the remaining departments.

B. Provision of Mental Health Services: About 40 departments transferred some MII to mental health facilities in 1983 but most do it infrequently. About 1,000 inmate transfers (or 4%) occurred nation-wide among 48 corrections departments, though some experts believe this estimate is low. Most mental health departments may refuse to accept transfers, especially of the assaultive, aggressive and violent inmates. These inmates appear to be the most difficult to manage cases in the view of both mental health and corrections agencies.

Of the inmates formally classified as MII about 94 percent were reportedly receiving some kind of care: about one-fifth inpatient care and the rest outpatient care. The formally classified represent, however only a fraction of all those who would be clinically judged "disordered" outside a prison setting.

About 13,000 of the 19,000 inmates classified mentally ill were in separate psychiatric facilities, units or programs whose major or secondary function was treatment. Thirty-three of 40 departments responded that they provided individual or group therapy to "at least some" MII.

NIMH has conducted a preliminary survey of state mental health forensic services for the "mentally disordered offender" (MDO) who is diverted from prison. Though not the direct target of this paper, some mentally ill inmates (MII) are transferred from prisons to these forensic facilities. These services also represent a potential treatment resource for other mentally ill inmates.

The Survey and Reports Branch, DBAS, NIMH estimates provisionally that about 40 percent of all speciality mental health organizations provide some forensic services. Psychiatric assessment is the most common forensic service, provided by over 1,000 organizations. Outpatient care and consultation are the next most common services, provided by over 900 organizations or 70 percent of the total. One hundred and sixty-seven of a total 280 State Mental Hospitals provided inpatient care to about 30,000 forensic patients in 1985.

Seven hundred forty-five multi-service mental health organizations provided one or more forensic services. Six hundred and eighty-four reported psychiatric assessments, 630 consultation, 580 outpatient care, while only 64 reported emergency detention, 57 inpatient care and 62 residential care.

According to preliminary, provisional NIMH data, nationally there were about 14,000 forensic beds and about 18,800 FTE forensic staff. Estimated total forensic spending was about $600 million. State mental hospitals spent about $500 million, outpatient clinics $11 million and multi-service organizations about $49 million.

Some state officials believe these provisional figures overstate the extent of existing treatment capacity.

A descriptive study conducted by Kerr and colleagues in late 1981 and early 1982 reports findings on 127 public facilities "that house and treat mentally disordered offenders" (1983; see also Shah, 1986). Though the MDO are generally beyond the scope of this paper, selected findings are presented for the convenience of the reader with broader interests.

## VI. SELECTED ISSUES

A number of key policy issues and questions arise regarding the provision of services to the MII.

### A. Global Issues

1. What should be the ultimate objectives of mental health services to the MII? E.g., a reduction of criminal recidivism? Humanizing the jail and prison environment? Or a number of positions between? Attempting to reduce recidivism strikes many practitioners in both service systems as utopian and unattainable.

2. Who are the "bad guys" in disputes over the MII? Responsibilities vary over the diverse states. Global blame or credit cannot be assigned to either mental health agencies or to corrections agencies.

3. To what kinds, levels and amounts of mental health services are MII entitled? This social question reminds us that this problem area is substantially complicated by individual, social and cultural values about crime, justice, punishment, freedom, responsibility and rights. As a result, strong feelings and emotionalism often color discussions.

B. Operational Issues

1. Which agencies should be responsible for services? The answers differ for jails and prisons.

It is widely agreed that, generally, services to jail MII should be provided by existing local mental health service providers and that jails should not get heavily into the mental health service business. Unlike jails, prisons tend to be large institutions, hold inmates for longer periods of time and often require an internal capacity for delivering mental health services. Interviewees argued

frequently that while there is no one best way to organize mental health services for the MII, corrections department ownership and control is probably best in many states.

Pointing to chronic shortages of professional mental health staff, Johnson (1987) believes that disturbed prisoners will have to be managed in ways that capitalize on the lay counseling services of prison officers who are in more abundant supply. Severe cases continue to require professional management.

2. Are the safety (custodial) goals of jails and prisons compatible with service goals? The early literature and some of the early interviewees for this paper argued that therapy (service) and custodial (safety) goals were incompatible. Research by Steadman, McCarty and Morrissey (1986) on about 40 jails challenges this conventional view. Problems of tension between service and safety may, however, be more real and troublesome in the case of prisons than in the case of jails.

3. Do philosophies of Mental Health and Corrections Agencies lead to conflict? Research on jails by Steadman et al. (1986) found normal "frictional" conflict between these agencies but not the disabling kind suggested by the literature. Again, this may be a more vibrant issue with respect to prisons where the type, level and result of conflict varies from state to state.

4. What are major barriers to improving care of the MII? The paper identifies and briefly discusses these:

divergent missions with respect to prison inmates; security and safety concerns of both corrections and mental health staff when dealing with difficult to manage cases like the assaultive, aggressive, violent inmate; limits on the professional capacity to predict with accuracy the likelihood of future danger from a "dangerous" inmate; and overcrowding which undoubtedly exacerbates some mental disorders, may induce new ones and may "overshadow" improvement of services as opposed to increasing physical space. Finally, to what extent changes in an inmate's "madness" may affect his/her "badness" (or vice-versa) is an ancient question with which many continue to grapple.

5. What program areas deserve priority attention? While priority areas will vary from state to state depending on local conditions, several common areas recur among state practitioners that deserve special attention: orienting and training police to identify and handle appropriately, especially through diversion, the suspect who is also mentally disordered; improving intake screening at jails and prisons; identifying "better" practices and "models" for managing the very difficult cases of aggressive, assaultive, and violent inmates; and strengthening treatment, aftercare and follow-up supervision.

## VII. FUTURE ROLES OF THE STATES AND THE NIMH

It seems clear that the development of policies and programs regarding the MII at the State and local levels are

the primary responsibilities of State and local jurisdictions and not of the Federal government. (Although excluded from this paper, future analysis should include programs of the Federal Bureau of Prisons.) Yet all levels have significant roles to play.

A. Both the States and the Federal Government: These roles include taking additional steps to focus sustained attention on this problem area; supporting and conducting documented accounts of "better" or "model" practices and service arrangements; highlighting the importance of screening and monitoring programs to avert inmate suicide attempts, and identifying and disseminating effective suicide prevention techniques; and collecting periodic data on the MII and services.

B. The States: Additional desirable activities for the States would include assessing the adequacy of existing service capability for the MII and clarifying agency roles; organizing programs of training for both corrections officers and mental health staff; convening workshops with experienced practitioners and professional experts to discuss workable means to manage the difficult aggressive, violent inmate; strengthening screening and follow-up functions; locating workable state models of service; and actively sharing their experiences with other states.

C. The Federal Government: The NIMH has important roles to play by continuing research support in this area; periodically collecting national data on state forensic

services; directing greater attention to short-term training of police, jail, prison and mental health personnel who come in contact with the mentally ill suspect, offender and inmate; and continuing to assist in the development of Community Support Programs. The NIMH should also explore possibilities for collaboration with the National Institute of Corrections and the National Institute of Justice on joint priority concerns. Finally, it is clear that additional policy analysis should be carried out directed to issues of concern to mental health and corrections policy-makers, state legislatures, and public interest groups. These documents and related material should be circulated widely to interested parties at the State and local levels.

## I. BACKGROUND

A. Introduction: An individual who is mentally ill may for one reason or another end up in jail rather than in a mental health facility. A felon may have a prior history of mental illness including stays in mental hospitals but these facts may not surface in court proceedings or prison records. A young man is sent to jail for a first offense, car theft, and on the second day he attempts suicide. Overcrowding may intensify a latent problem like aggressiveness. Some inmates may develop a mental illness during incarceration.

What is done in cases like this? What services, if any, are available to identify and treat mental illnesses among jail and prison inmates? What is the incidence and prevalence of mental disorder among prisoners? Who is responsible for developing and managing treatment services - mental health or corrections agencies? What relationships exist between these agencies -- indifference, competition, cooperation or antagonism? What major problems exist in this complicated service arena? What can and should be done to alleviate these problems?

This paper maps some of the terrain which lies between the mental health service system and the criminal justice system. It draws together the findings of several studies on a selected set of questions and issues. It comes to some general conclusions and makes recommendations about what might be done to advance public policy. The paper is highly

selective. It is an exploratory inquiry to identify key issues worth pursuing further in the future.

B. The Broad Context: The broad context of this paper is composed of interactions between two social systems: the criminal justice system on the one hand and the mental health service system on the other. Though there is no easy way to depict these interactions in detail, the flow chart on the next page is a simplified view of the way cases flow through the criminal justice system. The main horizontal lines represent the different paths of felony cases, misdemeanors, petty offenses and juvenile offenses. The case of an offender with a mental disability may follow any of these general paths.

Along the way, often during arraignment but also during subsequent steps including trial or later, an offender may be channeled into a forensic process. The purpose will be to obtain a professional determination of his/her competence to stand trial, a professional judgement as to whether the individual offender was sane or insane at the time of their alleged crime or whether they are dangerous to themselves or to others or so disturbed that they require immediate evaluation and treatment. These pre-trail and/or pre-sentencing interactions involve what is broadly called "the law and mental health." This important subject has been given considerable professional attention and grant support by the

[Flow Chart]

NIMH. The support has resulted in a number of important publications and source materials, most recently, for example, the excellent volume by psychiatrist, clinician and administrator Seymour Halleck on The Mentally Disordered Offender (1987).

C. Focus On The Mentally Ill Inmate (MII): As important as the "law and mental health" and topics related to pre-sentencing issues of the mentally ill may be, however, they lie in large part beyond the scope of this paper. We are concerned, instead, with mentally disordered (ill) adults who are not necessarily diverted to a mental health forensics evaluation or treatment program. Rather, they are sent to jail where they are in trial proceedings, await arraignment or trial, or have already been sentenced and are "doing time" in jail or prison. In the flow chart, these incarcerated convicts show up on the far right of the top two bold lines in a "penitentiary" or a "jail." In this paper we call them mentally ill inmates (MII).

The exhibit on the next page provides additional clarification about this target population. The major focus is on incarcerated mentally ill inmates in jails and prisons whether they have been recognized or diagnosed as mentally disordered or not. Also included, but not a major focus, are mentally disordered offenders who have been sentenced, incarcerated and then transferred to a forensic mental

Exhibit

Major Groups of the Mentally Ill
in the Criminal Justice System
Included Here

| INCLUDED | EXCLUDED |
|---|---|
| The Incarcerated Mentally Ill <u>Inmate</u> in Jails and Prisons:<br><br>o Mentally ill (disordered or disturbed) inmates in jails and prisons whether recognized/diagnosed or not.<br><br>o Diagnosed mentally ill offenders held temporarily in jail or prison facilities.<br><br>o Sentenced mentally ill inmates (convicts) transferred to forensic mental health facilities or to secure prison hospital facilities for treatment. | The Adjudicated Mentally Ill <u>Offender</u> in All Other Facilities:<br><br>o Incompetent to stand trial.<br><br>o Not guilty by reason of insanity.<br><br>o Guilty but mentally ill, and<br><br>o Dangerous civil cases.<br><br>Young mentally ill inmates in youth detention facilities.<br><br>Mental retardation as primary problem.<br><br>Alcoholism as primary problem<br><br>Drug abuse as primary problem.<br><br>Police diversions before arrest. |

hospital, a secure prison hospital or some other treatment facility.

Important, but beyond the scope of this paper, are adjudicated mentally disordered offenders who are not sentenced but diverted instead to a secure treatment facility. This group includes those judged incompetent to stand trial, those not guilty by reason of insanity, those judged "dangerous" and the "guilty but mentally ill." Others excluded here are the young, the mentally retarded, those inmates with a primary diagnosis of alcoholism or drug abuse, and, finally, the mentally disordered who are diverted by the police before having any contact with a court proceeding, jail or prison admission.

Unfortunately, the phrase "mentally disordered offender" is used in a variety of confusing ways. It may sometimes include sentenced convicts as well as offenders who are diverted from prison. It often includes the mentally retarded as well as the mentally ill and may include any "disorder" identified in the DSM III including alcoholism and drug abuse and addiction. We have elected to use the phrase "mentally ill inmate" to emphasize the population of sentenced and incarcerated convicts who are already "doing time" and are suffering a mental illness, disorder, or disturbance, usually of a severe to moderate kind. On occasion, however, we will be forced to use the expression "mentally disordered offender" (MDO) when research findings are presented in these terms

and cannot be disaggregated to focus only on the mentally disordered inmate.

Another term which is used in confusing ways is "forensic" service. It may refer to only diagnostic evaluations of offenders, to these evaluations plus treatment services for mentally disordered offenders, or, more broadly, to services to both offenders and convicts.

A second focus of this paper is on those institutional settings where the mentally ill inmate is normally located: jails, prisons and specialized treatment facilities.

D. Overlaps and Interactions: There are acknowledged overlaps and interactions between what is included here and what is excluded. Statutorily mandated and court-ordered services for the mentally ill inmate, for example, influence but do not guarantee the adequacy of screening, care and treatment services actually available to them. Similarly, discussion of the mentally ill and crime could, and often does, embrace the steep and rocky terrain of constitutional, statutory, judicial, administrative and other legal concepts and precedents as well as ideas of "justice" itself. A range of these important topics have already been the focus of some of the excellent research, writing and policy discussions of staff of the Antisocial and Violent Behavior Branch of the National Institute of Mental Health (see, for example, Shah, 1978, 1981, 1986 and McGarry and Shah, 1986).

E. Limited Evidence: In characterizing services for the MII we will cite the findings of a number of research studies and analyses. It will become clear, however, that the evidence about important aspects of this problem area is partial and uneven. Further research, data collection and analysis seems clearly indicated.

F. The MII and Values: The subject of mental health services for the mentally ill inmate (MII) is probably more complex than a comparable concern with any other subpopulation group. Because the issue area is embedded in society's response to crime, criminals, punishment, freedom and justice, it touches some of our deepest individual, social and cultural values, beliefs and opinions. Value considerations amplify the complexity of the area and make it sometimes treacherous.

G. Coverage of the Paper: The next part (II) describes selected characteristics of the primary institutional contexts of the MII: jails and prisons. It also presents the partial results of a number of attempts to estimate the prevalence of mental illness among the incarcerated. Part III recounts five principles intended to guide the development of jail services for the MII. Part IV briefly describes characteristics of prisons which is the second major institutional locale of the mentally ill inmate. Part V presents research findings on the corrections facilities where the MII are treated, including clues to the services and modes of

treatment provided. It also selectively recounts findings from a study of facilities where the "mentally disordered offenders" are housed during treatment. Part VI identifies several issues worthy of sustained attention. Part VII concludes with a set of recommendations about future roles of the states and the NIMH that should improve the understanding and care of the MII.

## II. CONTEXT OF THE PROBLEM: JAILS

Problems of providing services to the MII spring partly from the institutional settings and service patterns which already exist. There are several important features of jail (and later prison) settings worth noting:

1. Number and Size: There were about 3,338 jails in the U.S. in 1983 (Statistical Abstract 1986). They ranged in size from 1 or 2 person rural jails to large metropolitan facilities with 5,000 or more inmates. In 1978, the latest year for survey data, 65 percent of all jails had an average daily population of less than 21 inmates. Most inmates are held in large urban jails. While they represent only 4% of all jails, the 130 jails with over 250 inmates hold about 45% of all inmates.

2. Inmates: In mid-1984, there were an estimated 235,000 persons in local jails. About half of the adults had already been convicted. The other half were on trial or awaiting trial or arraignment. There were about 15 million adult admissions and releases for the year (Bureau of Justice Statistics, May 1986).

3. Auspices: Most jails are county or municipal facilities, though they are state-run in five small states (Connecticut, Delaware, Hawaii, Rhode Island, and Vermont).

4. Functions: They serve as pre-trial, short-term holding locations for the courts and as detention units for offenders with sentences under 1 year.

5. Geographic Location: About 75 percent of all jails are in the southern and northern central states. The south operates about half of all jails which housed 43% of the nation's inmates in 1978.

6. Length of Stay (LOS): The average stay of an inmate in a U.S. jail in 1982 was 11 days. Turnover is high.

7. Cause of Death: In mid-1984, 126 of the 278 deaths in jails were suicides (Bureau of Justice Statistics, 1986, p. 1).

8. Prevalence of Mental Illness: Though no comprehensive national data on the prevalence of mental illness in jails apparently exists, several sources provide clues.

Steadman et al. (1986) found six studies of prevalence rates of mental disorders among inmates in various jails. They summarize:

> These studies indicate that the true prevalence rate of severe mental disorders (i.e., psychoses) in local jails ranges from 1 percent to 7 percent, and the rate for less severe forms of mental illness (i.e., nonpsychotic and personality disorders) varies greatly, ranging up to 20 percent (Roth, 1980). Citing community prevalence rates reported by Neugebauer et al. (1980), Monahan and Steadman (1983) concluded that "the weight of evidence appears to support the assertion that the true prevalence rate of psychosis among the inmate population does not exceed the true prevalence rate of psychosis among class-matched community populations (p. 4)."

Detailed diagnostic information on MIIs in jails appears scarce. Teplin (1986) conducted a recent examination of the prevalence of "serious mental disorder among a randomly-selected group of 728 jail detainees" in the Cook County Department of Corrections in Chicago, Illinois funded by NIMH. She found that the lifetime estimated prevalence rates of several major disorders were higher than the estimates for these disorders in the general population based on NIMH-funded Epidemiological Catchment Area (ECA) research. The Cook County jail schizophrenia rate was 3.3% compared to 0.9% in the general population; 5.4% for major depressive episodes compared to 3.4%; and 2.3% for mania compared to 0.9%. Reportedly because the Cook County jail has a specialized program for mentally ill inmates, police may divert larger numbers to this facility than elsewhere.

Teplin notes that not all those identified in the study with severe mental disorder were detected by the jail and recommended for further evaluation. She claims that these study results indicate that some psychotic mentally-ill are being processed through the criminal justice system and are unlikely to be treated (Teplin, 1986, pp. 2-4).

9. Summary: Jails are, in brief, generally small, short-term detention facilities run by local governments with a high inmate turnover. An important jail mental health problem is a relatively high rate of suicide, especially among young admissions (about five times the rate

among their peers in the general population). In the face of these conditions, some guiding general principles for providing services for the MII in jails have been formulated. They are worth recounting briefly for their suggestive value.

## III. PRINCIPLES FOR JAIL PROGRAMS

What Principles Should Guide the Development of Jail Mental Health Programs? Steadman et al. (1986) examined a set of 43 jails located in 42 communities in 26 states. Based on their examination, prior experience and professional knowledge they derived a set of five "generic" principles to guide the planning of "humane and responsive" jail mental health programs:

Principle 1. "The mentally disturbed jail inmate must be viewed as a community issue." The jail is not an isolated institution and must be seen as "only one agency in a continuum of county services" (p. 115).

Principle 2. "The jail is and should remain primarily a correctional facility." "Local adult correctional facilities in the 20th century were designed for the purpose of incarcerating criminal offenders...Jails are not meant to be used as a specialized type of mental institution" (p. 119). The authors warn that building a service capacity for the mentally ill within a jail raises "a serious danger" that both police and judges will view the jail as an appropriate place to send the mentally ill even though they do not have to be incarcerated.

Principle 3. "Serious mental health needs among inmates require limited but high quality professional services in every jail." The authors endorse a court pronouncement on this issue:

> The jail is not a mental health facility, nor do administrators intend that it become one. It must, however, be staffed and organized to meet emergency situations, to make appropriate referrals, and to carefully care for and protect those who must be housed in the jail for whatever reasons despite their mental illness (Inmates v. Pierce, 489 F. Supp. 638, 1980).

Minimal staffing is important. But most efforts in this area center on diverting the mentally ill before they are actually taken into custody.

The authors recommend a program in place at the detention facility in Contra Costa, California. It is characterized by "promptness and flexibility, which place a premium on inmate management rather than on treatment in the classical sense" (p. 126, underlining added).

Principle 4. "Correctional Administrators should concentrate their efforts on developing mental health services in the areas of identification, crisis intervention, and case management at release."

Jails are short-term, "people processing institutions." "Their focus is not on long-term detention and basic personality change or rehabilitation ...jail services should be designed to help inmates cope with the stresses of incarceration; efforts to address the broader goal of long-term treatment are best reserved for other agencies of the community" (pp. 126 and 129).

Principle 5. <u>There is no one best way to organize a jail mental health program</u>.

"Different strategies are needed because county jails vary so greatly in size, structural characteristics, level of perceived need, and resources available in the community's existing mental health service network" (pp. 129-130). Whether to provide services through a contract, a joint staffing arrangement, direct jail staff or other arrangement "is a decision that depends on a host of historical, political, fiscal, and community factors" (p. 130).

Finally, Steadman, McCarty and Morrissey judge that "there is every reason to believe that the quality of mental health care in our nation's jails is as problematic today as it was 10 years ago, when concerns were first expressed about the welfare of deinstitutionalized mental patients who might wind up behind bars" (p. 134).

In addition to showing up in jails, mentally ill inmates also appear in prison settings that are briefly described in the next part.

## IV. THE SECOND CONTEXT OF THE PROBLEM: STATE PRISONS

Prisons are the second major institutional setting of the mentally ill inmate (MII).

A. Prison Characteristics: Statistics on prisons are partial and of varying currency. According to the Statistical Abstract of the United States (1986) and the Bureau of Justice Statistics Bulletin (1987) selected characteristics of state prisons include the following:

1. Inmates: About 463,000 at the end of 1986.

2. Facilities: A total of 791 "correctional facilities" in 1984 (903 in 1987). Five hundred sixty-eight were classified as "confinement" facilities. Two hundred and twenty-three were "community based." About 104 prisons housed 1,000 or more inmates. One hundred thirty-nine housed 500-1,000 prisoners. The balance had less than 500 inmates.

3. Security-Level: 109 were maximum security facilities, 98 medium security and 62 minimum security. Twenty-six were devoted to work release and education purposes. About half of all inmates were in maximum security facilities.

4. Staff: Approximately 94,000 full-time; 2,700 part-time in 1984.

5. Utilization: In 1984 state correctional facilities were 11 percent over capacity. Overcrowding was widespread over the U.S. Ten thousand prison inmates were temporarily housed in local jails in 1985.

6. Length of Stay (LOS): Prison sentences ranged from an average (median) minimum of 4.3 years to an average (median) maximum of 8.6 years. Most prisoners are released before they serve their maximum sentence.

7. Jails and Prisons Briefly Compared: In brief comparative summary, jails and prisons are different types of correctional institutions. Prisons hold inmates much longer than jails, for more serious crimes, in larger complexes and under conditions which make the delivery of mental health services seemingly more difficult. Mentally ill inmates, however, appear in significant numbers in both correctional settings.

B. Extent of Mental Illness Among Inmates:

1. Prevalence of Mental Illness in Prisons: Three studies provide clues. In the first study the National Institute of Corrections (1985) reported the results of a 1983 national survey of the mentally disordered in prisons conducted by the research and planning staff of the New York State Department of Correctional Services. Responses from 48 State Corrections Departments suggest that about 34,000 inmates are officially classified as either mentally ill or mentally retarded or both. About 24,000 (six percent of the total 400,000 inmate population in those 48 states) were classified as mentally ill. Only about 250 were dual-diagnosed. The report cautions the reader that these figures do not represent true prevalence. Rather they reflect a set of

policies, procedures and practices that result in official classification only. The true prevalence is probably higher.

The number of classified MIIs in each corrections department varied widely over the 50 states ranging from a handful to over 3,700. A minority of the departments housed over a majority of the MII. Twenty percent of the 48 responding departments, for example, accounted for two-thirds (16,000) of all the inmates classified mentally ill.

About 80 percent of the 48 responding departments estimated that they classified (or actually counted) 1.0 to 7.5 percent of their total inmate population as mentally ill (pp. 15-18).

In a second study of the prevalence of mental disorder in prisons, Collins and Schlenger (1983) estimated the "prevalence of psychiatric disorder by diagnostic category among 1,149 male felons at the time they were admitted to North Carolina prisons." They used the Diagnostic Interview Schedule (DIS) developed with support from NIMH to determine whether incoming prison inmates "have ever in their lives experienced symptoms of sufficient severity to justify one or more of the diagnoses included in the analysis." They found that lifetime prevalence rates from three major disorders were substantially greater among inmates than in the general population: antisocial personality (about six times greater), alcohol/dependence (two to three times greater), and substance abuse/dependence (also two to three times greater).

These problems seemed to be associated with a history of prior arrests. The authors point out, however, that there may be some circularity here since "arrest" is itself a criterion for the diagnosis "anti-social personality" and heavy drinking and the use of illegal drugs increase the likelihood of arrest.

The third study of the prevalence of mental illness among prison inmates was conducted recently by Steadman, Fabisiak, Dvoskin and Holohean (1987). It was based on a survey of three levels of mental disability (mild, significant and severe) among New York state's roughly 36,000 prison inmates in mid-1986. The survey employed two disability scales: a modified version of the Nurse's Observation Scale for Inpatient Evaluation (called PSYSUM for psychiatric summary) and a modified version of the Community Activity Scale (CADS). Results were assessed against levels of disability in a range of regular psychiatric patients. The study examined a total sample of 3,684 inmates that included 3,332 (9.4%) of the inmates in the general prison population and 352 (98%) of the 360 inmates in prison mental health units. (Central New York Psychiatric Center, an inpatient hospital, was not included in this round of surveys.)

The authors point out that groups of inmates with measured psychiatric disabilities on the one hand and functional disabilities on the other "greatly overlap." They conclude in their preliminary analysis that 8% of New York's

36,144 prison inmates showed "severe" psychiatric and/or functional disabilities while another 16% showed "significant" disabilities. The next step in their analysis will be to determine the specific nature of inmate disabilities and then to make judgements about corresponding service requirements.

2. Adjudicated Mentally Ill: Most state departments of correction report that they "never" have prior custody of those "adjudicated mentally ill" (i.e., those determined to be incompetent, insane, guilty but mentally ill or "abnormal offenders" -- e.g., statutorily defined sex offenders). For example, only 12 of the 50 departments reported ever receiving individuals to be held pending a determination of their competence to stand trial. Nine departments held 128 in custody; 80 were in just 2 of the departments. Most are held at the local level in jails or hospital forensic units awaiting a competency determination. Those found incompetent or insane are usually held in facilities of the State department of mental health (National Institute of Corrections, pp. 19-20).

By 1983 under laws in 8 states an individual could be found "guilty but mentally ill" and yet not insane. Though most state statutes require treatment which is "psychiatrically indicated," these offenders may still show up in general prison populations. Similarly, as some states (e.g., California) have abolished programs for "abnormal offenders,"

these individuals may also enter general prison settings (pp. 20-21).

There are, in short, identifiable and significant numbers of mentally ill inmates in both jails and prisons though the true prevalence may be higher than some available estimates. The next Part (V) describes in some detail the corrections facilities which house the MII for treatment. It also briefly recaps key findings of a study of facilities for "mentally disordered offenders." The reader should remain alert to shifts in the target population under examination.

V. CORRECTIONS FACILITIES FOR THE MII:

A. Identifying the MII: Most MII have not been identified as such by the courts before imprisonment. If their illness is to be detected it must be identified at the time of imprisonment and at subsequent times during incarceration. The New York State survey (National Institute of Corrections, 1986) identified these basic elements of a mental health screening and identification process: a review of records; observation; testing; interviewing; and referral. They were combined and distributed over the 52 state-level corrections departments in the following way:

| | Number of Departments |
|---|---|
| Record Review, Staff Observation and Referral | 6 |
| These three plus interviews | 9 |
| These three plus tests | 2 |
| All five elements | 33 |
| No response | 2 |
| Total | 52 |

Source: National Institute of Corrections, 1985, adapted from Table 5, p. 22.

The effectiveness of these alternate sets of procedures has not been assessed.

Mental health professionals usually conduct intake interviews (a psychologist in 17 departments or the "psychology staff" in another 12) though there are a wide range of

others involved in other departments. Eight had no routine interview.

B. Provision of Services in Corrections: The study revealed a number of major features of mental health services provided by corrections departments.

1. Transfer of the MII to other Agencies: About 40 corrections departments transferred some MII to other agencies in 1983 but most did it infrequently. About 1,000 inmate transfers (four percent) occurred nation-wide among 48 departments. As with most corrections practices variation across the states was very wide. Some states, for example, transferred only the chronically psychotic while others transferred those in acute distress for short stays.

2. Worst Cases: Some inmates (e.g., the acutely psychotic) may reportedly become "ping-pong balls" between mental health and corrections facilities. Assaultive, aggressive and violent inmates pose both threats and challenges to the two systems. Most mental health departments have the authority to refuse to accept the transfer of MIIs and may send them back to corrections unilaterally. Mental health departments cite several reasons for using this authority:

- o A lack of bedspace or appropriate programming;
- o An inmate may not be evaluated as mentally ill;

- An inmate may be judged too dangerous for safe management in an available setting; or
- Presenting problems may not be judged amenable to treatment (National Institute of Corrections, pp. 25-26).

The corrections survey report concludes:

> Indeed some corrections respondents expressed the view that those inmates who were most disturbed and difficult to manage or treat in corrections were also those least likely to be accepted or retained in facilities administered by other agencies ... the vast majority of inmates classified as mentally ill by corrections remain within the correctional departments during their criminal confinement (p. 26).

3. The Level of Services in Corrections: About 94 percent of the classified MII in the 40 departments were receiving "some psychiatric care." About a fifth were receiving inpatient care and the rest outpatient care. Again classification, counting and service practices vary widely over the states. For example, 8 departments claimed that all their MII were receiving inpatient care while seven departments reported no inpatient care.

4. Separate Facilities: Thirteen thousand of the approximately 24,000 classified MII were in separate psychiatric facilities, units or programs whose major or secondary function was treatment of the mentally ill. Twenty-two departments reported that from 50-100 percent of

their MII were in separate arrangements. Three departments had no separate arrangements (pp. 27-28).

5. Modes of Treatment: Thirty-three of 40 responding departments provided individual and group therapy to "at least some" MII. Twenty-three departments reported individual therapy for "most or all" MII. Fifteen reported group therapy for "most or all" MII. Psychotropic medication for "most or all" MII was reported by 13 departments. Twenty other departments reported that "some" MII were under medication. Twenty-six departments reported no use of electroshock while 12 reported that "few or none" of the MII were given that treatment.

A wide range of other types of treatment are employed including coping skills training (17 departments), pastoral counseling (16), recreational therapy (14), therapeutic community (13), biofeedback (9), etc.

Each department had at least one full-time psychologist but most also used part-time consultants for psychiatric coverage. Licensed psychologists provide most individual and group therapy. Psychiatrists "typically provide direct care to only 'some' or a few" of the MIIs (National Institute of Corrections, 1985, pp. 28-29).

In addition to special purpose studies of services, the NIMH has begun to develop a recurring survey of facilities for mentally disordered offenders.

C. Forensic Services for the MII: The Survey and Reports Branch of the NIMH has begun an examination of forensic activities in the specialized mental health service system. A survey of treatment activities in state correction departments is also planned. Ronald W. Manderscheid, Chief of the Branch, reports that preliminary results indicate that a substantial share of all public psychiatric beds appear to be used for forensic purposes.

Provisional data indicate that about 40 percent of all specialty mental health organizations provide some forensic services. Provided by over 1,000 organizations psychiatric assessment is the most common forensic service. Outpatient care and consultation are the next most common services, provided by over 900 organizations or 70 percent of the total that provide forensic service. One hundred and sixty-one of a total 280 State mental Hospitals provided inpatient care to about 30,000 forensic patients in 1985.

Seven hundred forty-five multi-service mental health organizations provided one or more forensic services. Six hundred and eighty-four reported psychiatric assessments, 630 consultation, 580 outpatient care, while only 64 reported emergency detention, 57 inpatient care and 62 residential care.

Nationally there were a total of about 14,000 forensic beds with an occupancy rate of about 88 percent and about 18,800 FTE forensic staff. Total spending was about $600

million. State mental hospitals spent about $500 million, outpatient clinics $11 million and multi-service organizations about $49 million.

Some State officials believe that these provisional figures overstate the extent of existing treatment capacity.

D. Facilities for the Mentally Disordered Offender (MDO): A study by Kerr and Roth (1983) adds some further detail about services for "mentally disordered offenders," including, in this instance, those found not guilty by reason of insanity; those incompetent to stand trial; "special offenders" like statutorily defined sex offenders; juveniles; and defendants being evaluated for competence to stand trial or being examined for criminal responsibility. As a result of this focus, the service capacity described may be broader than that readily available for the convicted and incarcerated mentally ill inmate. The universe of facilities examined, however, may be similar for both groups. Highlights of this study are provided as a convenience to readers with an interest broader than the MII.

In late 1981 and early 1982 Charlotte A. Kerr and her colleagues identified, screened and conducted a descriptive study of 127 "public facilities that house and treat mentally disordered offenders." Funded by the Center for Studies of Crime and Delinquency, NIMH, the study updated and expanded upon earlier studies of the same types of facilities in 1969 and 1978. The study was based on a national mail survey

(with both closed and open-ended questions), follow-up telephone interviews with 60 administrators, reviews of both the legal and social science literature and site-visits to eleven facilities. The "final draft" report of this substantial study which is referenced here has since appeared in published form (Shah (ed.), 1986). Findings relate only to the 127 facilities covered by the study and not to all facilities which might have some contact with the mentally ill offender.

1. Auspices: Care and treatment of the MDO is primarily the responsibility of State Departments of Mental Health (79 of the 127 respondents). Eighteen are corrections facilities and the rest are under social services or other auspices. Nearly all facilities (121 of 127) are state administered. Sixty percent are units within larger organizations.

2. Eligibles: Females are eligible for admission to 46 facilities; only 4 are dedicated exclusively to them. Ninety-eight facilities limit admission to adults, 17 are dedicated to juveniles and 12 accept both.

3. Capacity ranged from 10 to 1,254 persons. "Separate institutions were larger with a medium of 101-250 capacity. Separate units (e.g., psychiatric units of prisons or forensic units of mental hospitals) had a smaller median capacity of 51-100. Total residents numbered about 16,000; 13,600 were adults.

4. Populations: Separate institutions (rather than units within larger institutions) house about two-thirds of all residents. Eighty-six percent reside in facilities for adults only. Fifty-eight percent of the entire population was concentrated in 18 facilities with populations over 250.

5. Legal Status of Residents: The MDO (mentally disordered offender) resident population was "approximately equally divided" among these categories:

- Incompetent to stand trial;
- Not guilty by reason of insanity;
- Legally defined "sex offenders";
- Mentally ill prison inmates transferred for treatment to mental health facilities.

A significant number of residents undergoing evaluation for competency are also included. These different categories of MDO require a variety of treatment capabilities.

6. Diagnosis: There was a diversity of diagnoses, including all major categories of DSM II and III. The most frequent were schizophrenia, substance abuse and conduct disorders. Sixteen to 19 percent had received secondary diagnoses of mental retardation (p. 6-9).

7. Demographics: About five percent were under 17 years old and about five percent were over sixty-five. Most (58 percent) were between 20 and 34. The ethnic composition of corrections facilities for the MDO was reportedly about the same as for general corrections facilities. There were,

however, a larger proportion of whites (about 52 percent) in mental health facilities for the MDO than in general mental health facilities (about 44 percent).

8. Treatment: Ninety percent of the facilities reported regular preparation and review of treatment plans. Psychotropic medication was the most widely used treatment, available in nearly all facilities for about 60 percent of the residents. Ninety percent of the facilities reported that they offered group and individual therapy at least weekly to medians of 60 percent and 34 percent of the residents. Use of ECT, insulin shock and other somatic therapies "has virtually disappeared."

9. Larger Facilities (over 50 residents) seemed to offer "more highly structured treatment programs" than smaller ones.

10. Security Status: About one-third of the facilities classified themselves as "maximum security," 19 percent as medium and 10 percent as minimum.

11. Staff: These facilities had an overall median of 136 staff members to 100 residents. The aggregate ratio of treatment staff to security staff was 1.75 to 1 in Corrections, 11 to 1 in mental health and 13 to 1 in social service and other facilities, though some of this seeming variation may be due to differences in staff nomenclature (p. 6-16).

12. Key Areas of Management Concern included management of suicidal/homicidal residents; problems due to the

presence of both males and females; staff turnover; and balancing treatment and security concerns (p. 6-18).

Thus far we have reviewed the three major institutional locales where the MII are ordinarily located: jails, prisons and treatment facilities. The next Part (VI) identifies a set of key policy issues related to services for the MII. The final Part (VII) discusses possible roles for the states and the NIMH to help improve services for the MII.

## VI. SELECTED ISSUES - SERVICES FOR THE MII

A number of key policy issues and questions arise regarding the provision of services to the MII. A few can be excluded or passed by quickly. Others require sustained attention.

### A. Global Issues:

1. What should be the ultimate objectives of mental health services to the MII? A variety of opinions range from (a) reduce criminal recidivism to (b) humanize jail and prison environments, with (c) many positions in between. The formulation of precise service objectives should be left to individual state and local jurisdictions that face specific concrete service problems. Several State Mental Health Forensic Directors believe that attempting to reduce recidivism through jail or prison mental health services is a utopian and currently unattainable objective.

A recent report of the Virginia Department of Mental Health and Mental Retardation points to a set of court decisions that "prisoners have a right to treatment for serious mental disorders, particularly those conditions that would result in needless suffering if left untreated," though the courts have not defined an inmate's right to "rehabilitation" designed to advance functioning.

2. Who are the "bad guys" in disputes over the mental health needs of the MII? In some state and local settings there are reportedly amicable and mutually

supportive roles played by mental health agencies on the one hand and corrections agencies on the other. In others there is clear tension and in some cases blatant antagonism. Global blame or credit cannot be assigned among the stakeholders associated with this social problem area. In some states mental health agencies have taken a lead role, in others corrections agencies. In yet others collaboration has occurred, sometimes induced by court orders.

3. To what kinds, levels and amounts of mental health services are the MII "entitled?" The nature of this social question illustrates important dimensions of the problem of mental health services for the MII, some of which we have already mentioned. First, the problem area is very complex. More complex, it seems to us, than the service issues related to nearly any other subpopulation group. Second, discussions of criminals, crime, justice, punishment, retribution, restrictions on freedom, and "rights to treatment" touch the most basic of our individual, social, cultural and human values, beliefs and opinions. As a consequence, strong feelings and emotionalism sometimes color inquiries and discussions of policy issues and alternative solutions. This social question has not only technical but major moral and ethical overtones as well.

B. Operational Issues: Beyond these three general issues are several other basic questions about the provision of services to the MII.

1. Which Agencies Should Be Responsible for Services, Mental Health Agencies or Corrections Agencies? The answers are different for jails and prisons.

Jails: It seems fairly widely agreed that under normal circumstances mental health services to jail inmates should be provided by existing local service providers like mental health clinics and centers or by contract providers. Most jails are small, inmate length-of-stay is very short (about 11 days) and services which are required tend to be for screening, intervention in crises and emergency care. As noted earlier, jails are not meant to be mental health clinics. Building service capacity there may encourage rather than discourage police and judges to refer individuals to jails for mental health services even though they are not to be legally detained.

Prisons: Unlike jails, prisons tend to be large institutions, hold individuals for longer periods of time and often require an established internal capacity for delivering mental health services along with general health services. Several interviewees mentioned that inmates may become "ping-pong balls" or end up with "bus therapy" in the absence of adequate, safe and effective prison treatment alternatives. Building service capacity under the administrative control of the corrections department may also be better for prison inmates. Transferring them back and forth from one type of environment to another may be destabilizing and

anti-therapeutic. It may also raise difficult questions of safe logistics and arrangements for treatment.

Several interviewees suggested that in some states the initiative for services should definitely be taken by corrections departments. An experienced former Director of a mid-west corrections department who has worked in several state systems believes that many corrections officials have "wearied of the problems dealing with mental health agencies" and have decided to "go it alone." He believes that many effective approaches to the mentally disordered inmate can be found among the experienced staff of state institutions. Sustained, interactive opportunities for prison staff to help solve the care and treatment problems of the MII must be created. They should be assisted, however, by skilled, experienced and knowledgeable outside consultants.

In a clear and practical discussion of "Hard Time" in prisons, Johnson (1987) notes:

> Mentally disturbed prisoners have been called the number one health problem behind bars and identified as a group that recidivates at an unusually high rate (Wiehn, 1982; Toch, 1982). They are, moreover, a growing problem in corrections, yet there is no indication that mental health staffs have grown apace or that treatment practices are adequate (150).

Johnson believes that there will never be enough professionals for the prison mental health problem because pay is comparatively low, personnel tend to be foreign and end up

doing administrative tasks. He suggests that professional services can be viewed as teaching better adjustment to prison life through the education of inmates and concludes:

> Disturbed prisoners will have to be managed in ways that capitalize on the lay counseling services of prison officers which are in more plentiful supply than professional psychiatric services (p. 151).

Several interviewees felt that casting the issue of agency responsibility for the MII into two grand alternatives (mental health versus corrections) was misguided. They subscribe instead to a set of guiding principles shared by this author:

- o There are <u>widely varying conditions</u> with respect to services for the MII across states and localities;
- o No single or standard approach is universally suitable for this wide diversity of problem situations;
- o As a result, approaches, arrangements and solutions must be fitted, tailored and adapted to concrete state and local circumstances (Kimmel, 1981; Steadman 1986).

Several interviewees echoed these principles and pointed to a variety of basic state approaches to services for the MII; e.g.,

- o The state mental health agency has primary responsibility and authority, as in New York state;

o The Corrections Department directly administers, staffs and operates specialized services for the MII as in the evolving North Carolina system;

o There are collaborative, joint arrangements between mental health and correctional authorities, as in evolving systems in Missouri and Florida;

o There are special innovative programs worth examining within more conventional state systems as in Maryland.

2. Are the "safety" (custodial) goals of jails (or prisons) compatible with "service" (therapy) goals? The early literature on barriers to providing adequate and appropriate services to the MII, as well as some of the early interviews for this paper, focused on the potential, even likely, incompatibility between the goals of corrections personnel and those of mental health personnel.

Based on their examination of 42 jail situations, however, Steadman et al. (1986) concluded that:

(1) "The 42 jail mental health programs were moderately effective in meeting safety goals."

(2) "...the crucial structural factor [for safety] is where the services are delivered, not which agency delivers them." (p. 74)

(3) "...mental health programs associated with smaller jails, as well as those with relatively low levels of

perceived conflicts, are more successful in attaining service goals." (p. 74)

(4) Finally, and in summary, "One of the more important findings ... was a rather strong positive relationship between safety and service goal effectiveness. ... In short, it appears that both goals are compatible and mutually supportive in jail settings" (p. 75).

It is important to note that the author's "sample" included a special purpose set of jails, many of which could be assumed to be above average in program quality and effectiveness. Further research and study of an additional share of the nation's nearly 3,400 jails (selected through a more randomized sampling process) would cast more detailed light on this issue area.

A comparative examination of basic types of prison mental health services could serve as a basis for the formulation of a set of "principles" to guide program development.

3. Do Philosophies of Mental Health and Corrections Agencies Lead to Conflict? Steadman et al. (1986) state the problem sharply: "It has become almost axiomatic in sociological analyses . . . to assume that their respective ideologies are inherently contradictory." The correctional literature argues that "conflict between custodial and professional staffs is one of the major administrative problems in the field of corrections."

Steadman et al. examined 232 responses of correctional and mental health staff in their study of 43 jails. They employed two scales to tap the level of day-to-day conflict among staff and concluded:

> First, the overall level of conflict in mental health service programs for this type of correctional facility is less than would be suggested by the prison and state mental hospital sociological literature. Second, differences found in the amount of conflict reported by security staff and mental health staff are not found when conflict measures focus on organizational goals (p. 91).

The conflict detected was characterized as "frictional" and common in organizations. It did not seem to interfere with the accomplishment of either security or service goals.

4. What are Major Barriers to Improving Care of the MII? There are a number of basic conditions and dilemmas which may constitute barriers to improving the care and treatment of the MII.

a. Divergent Missions: Despite findings about the compatibility of custody (safety) and service (therapy) goals in jails, these issues may be more real and active in State prison settings where they have not, to our knowledge, been explored in a systematic way. One way to improve mutual understanding and shared goals among mental health and corrections staff would be to increase interaction around concrete problems related to the MII. Another is to tap the insights and approaches of those who have worked with the MII as practitioners in both settings.

b. Intractable Behavior Cases: The assaultive, aggressive and violent inmate seems to present the greatest management and treatment problem to both mental health and corrections agencies. Since prisons are designed and intended to remove criminals from the rest of society and to ensure safety for corrections personnel, service professionals and other inmates, the aggressive MII may pose the greatest treatment challenge to both systems. Like jails, prisons are not designed or intended to be mental health centers or hospitals. Effective ways to deal with the destructive inmate appears to be a topic of considerable importance to both mental health and corrections specialists.

c. Effectiveness, Dangerousness and Release: Neither research nor professional experience yet provides a way to predict with accuracy whether an inmate will be dangerous in the future either after treatment or after release from prison. Similarly, aspirations to reform criminal behavior through mental health services in jails and prisons is probably both utopian and impractical. As one well-placed forensics professional put it:

> We have yet to produce the evidence that forensic mental health services are effective [for that purpose]. It is our responsibility to produce that evidence.

Another forensics professional urged "humility" and caution in the claims which might be made for the benefits of forensic mental health services.

d. Overcrowding: The growth of prison populations has been outstripping the capacity of existing facilities for a number of years. The pressure of overcrowding has induced most states to seek additional space. In over half of all states, for example, consideration was being given just a few years ago to converting under-utilized state mental hospital facilities to prison use (see, e.g., Kimmel, 1986). New construction of correctional facilities is now extensive. Overcrowding, according to several interviewees, has increased the likelihood of mental disturbances among some inmates. Another consequence may be, as Steadman et al. (1986) suggest, that the problem of overcrowding may have "over-shadowed" other local correctional concerns including the improvement of mental health services for the MII. On the other hand, the construction of new prison facilities opens opportunities for allocating some of the new space to treatment purposes.

e. The "mad" and the "bad": Several analysts have pointed to the dilemma posed by the mentally ill offender. How much of the behavior which led to conviction or diversion can be attributed to the individual's madness and how much to his/her badness? Conversely, how much of the badness will be relieved by treatment of the madness. This is an ancient issue. The tension persists between society's twin imperatives to protect itself against harm and danger and yet to care for its sick and disabled.

f. Interagency Neglect: Despite the reasoning and perspective that can be brought to bear on this problem, who should be responsible for exercising leadership and initiative to improve services for the MII remains an enduring issue in many states. The practical answer undoubtedly lies in a different direction in every individual state setting. There is, as stated elsewhere, no "one best way" to organize for services to the MII. The past history of relations among relevant agencies, the state of service system evolution, budgetary opportunities and the degree of pressure from judicial sources have and will heavily influence the details of arrangements established by any given state. Yet there seems to be a developing consensus among many state-level practitioners in both corrections and mental health that effective and appropriate services for the MII, especially for the difficult to manage cases, may be more readily developed within correctional programs and under their administration.

g. Service Financing: Several interviewees pointed out that neither mental health nor corrections normally gets high priority public financing. To improve services for the MII one interviewee stressed the practicality of moving toward evolving financing opportunities. Since corrections funding has recently grown to relieve overcrowding and undesirable prison conditions, services for the MII

may be sought more successfully through corrections than through mental health auspices.

5. What Program Areas Deserve Priority Attention? Appropriate answers to this question will vary from state to state depending on local conditions. There are, however, a number of common areas identified recurringly by state practitioners that are worth special attention.

a. Police Diversion: Police attitudes and practices toward individual suspects who display behavioral evidences of mental disorder heavily influence whether they will be sent to jail or diverted to an alternative setting for evaluation, referral or treatment. There has been sustained concern over the past decade that the deinstitutionalized mentally ill have been sent to jail in growing numbers for minor infractions. Along with tighter civil commitment laws and a shortage of sheltered housing for the mentally ill homeless, policies and practices of local police are important factors which determine whether mentally disordered suspects and misdemeanants are appropriately screened before incarceration.

In a notable attempt to provide concrete training guidance to police officers Director Hayes of the Police Executive Research Forum states bluntly:

> The virtual absence of community mental health emergency services has left police agencies, by default, to answer the urgent and routine needs of the mentally ill. Their response to date has not always been exemplary, but, in fact, they have not

> received any significant guidance from the mental health profession on how to manage the mentally ill. Rather, police have found themselves under attack for their handling of the mentally disabled . . . (Murphy, 1986, p. i).

Murphy reports that the average time devoted to mental health in police training curricula was only about 4.3 hours. But he also describes some hopeful exemplary police programs:

- The Sheriff's Department in Galveston, Texas created a special unit staffed 24 hours a day by peace officers certified as emergency medical technicians and mental health specialists. They receive disordered subjects from patrol officers or go on the scene in response to calls.
- Every patrol officer in Madison, Wisconsin receives comprehensive, indepth training in the management of the mentally ill. Although officers are expected to reach a disposition on their own they are backed up round-the-clock by both county and police mental health staff.
- Birmingham, Alabama operates a 24-hour emergency service for persons in difficulty. Staffed by social work community specialists it provides on-site assistance and takes responsibility for case disposition.

These programs have substantially reduced inappropriate jail admissions and increased police understanding of the mentally disabled offender. Elements of effective programs identified by Murphy include a 24-hour response capability, trained staff, a clear delineation of roles and responsibilities, and close liaison between participating agencies. In

a new and separate volume Finn and Sullivan (1987) describe a dozen cases of interagency "networks" established to improve the "Police Response to Special Populations," including the mentally ill.

Orientation and training of police officers and jail intake personnel about the signs, symptoms and management of mental disorder is a major and important area where mental health agencies can play a direct and constructive role. It is also an area to which state and federal law enforcement training funds could be usefully directed. Improving the interactions between law enforcement, criminal justice and mental health systems deserves intensified and priority attention by states counties and cities.

b. Screening at Intake: Most inmates do not pass through legal and forensic processes designed to assess their mental status. Yet a small but significant percentage of them have mental disorders which go undetected, especially in the isolation and confinement structures of prisons. If these mentally disturbed are to be given even minimum health care, they must be identified through effective professional screening at intake. A screening function should be designed as an integral part of a prison mental health service to avert suicide, identify cases for special treatment and spot potential future cases of psychiatric disfunction.

c. Managing Difficult Cases: Many practitioners stress the importance of sorting as best as possible the clinically mentally ill from cases of difficult-behavior problems. Many believe that positive care can be given to the severely mentally ill, like inmates with schizophrenia, organic brain syndrome and other psychoses. Cases of aggressiveness, "acting out" and violence which are not clinically linked to mental illness, however, reportedly pose major unsolved and continuously disruptive problems of management for prison officers. These are typically the cases with which neither mental health nor corrections staffs chose to deal because they tend to be beyond ordinary "treatment" and management. Formally undiagnosed, disruptive inmates are not ordinarily under medication and may pose threats to both inmates and correctional staff. The Deputy Director of Adult Correctional Institutions in a southern state believes that this group deserves joint priority attention from both corrections and mental health specialists. He proposes a set of national panels and conferences to address these troublesome cases.

d. Aftercare: Even when the mental disabilities of an inmate may be spotted at intake and treated during incarceration, some cases require close follow up and monitoring upon release. It is the strong belief of a senior mid-west corrections official that recidivism among these

disabled inmates could be reduced substantially through appropriate follow-through and follow-up supervision.

## VII. FUTURE ROLES AND ACTIVITIES:

It seems clear that the development of policies, practices and programs regarding the MII are the primary responsibilities of state and local jurisdictions and not of the Federal government. It is equally clear, however, that some past Federal activities have proved valuable to mental health, forensic and corrections practitioners and should be continued. Some activities should be pursued by both states and the Federal government.

### A. Both States and the Federal Government:

1. Focus on the Problem: Both the States and the NIMH (perhaps in collaboration with the National Institute of Corrections) should focus greater attention on the problem of services to the MII and related concerns. This might be done through convocation of state-level officials from both mental health and corrections agencies for interactive learning, identification of desirable and workable programs and practices, discussion of both convergent and divergent goals and objectives and presenting effective practices and workable models for common troublesome problems like the functioning but disruptive and violent inmate.

2. Document Better Practices: Nearly all interviewees stressed, as we have, the wide variability across the states and localities in conditions and practices related to the MII. Yet there is a clear and widespread interest, at the State level in particular, in learning of effective

approaches, practices, programs and policies which are "tried and tested." NIMH should play a role in encouraging, supporting and disseminating documented accounts of "better" or "model" practices. The states could both volunteer for and conduct case studies of exemplary models and practices.

3. Prevent Suicide: Suicide is a major cause of death in jails and prisons, especially of youth who may be first offenders. Suicide usually occurs during the first few hours or days of incarceration. Screening and monitoring programs are especially valuable to prevent jail and prison suicide attempts. They should be among the top priorities and front-line programs of both jails and prisons. NIMH has a role to play in pointing out that jail and prison suicide is commonplace and can be reduced. The Institute can also help identify and disseminate effective suicide detection and prevention techniques.

B. The States: Additional desirable activities for the individual states would include:

1. Assess Services: Convening interagency task forces to examine the extent of mental disabilities among jail and prison populations, assessing the adequacy of existing service capability, clarifying agency roles and responsibilities and setting an agenda of future action to implement remedies to major existing problems. Assessments have already been done in Virginia, Pennsylvania and Washington.

2. Training: Organizing programs of training (including orientation, courses and workshops) for both corrections officers and mental health staff who deal with mentally ill inmates.

3. Difficult to Manage Cases: Convening workshops and conferences of experienced practitioners and professional experts to explore practical and workable approaches to the management of aggressive, destructive, violent inmates.

4. Screening and Follow Up: Ensuring the development of minimal intake screening and post-release follow up of the mentally disabled inmate.

5. Explore Existing Models: The several states and localities are natural laboratories for the development of a range of approaches to the delivery of services. States like Virginia have found it very beneficial to take the time and trouble to visit existing service mechanisms in other states and localities. Excessive state restrictions on staff travel to get first-hand observation and accounting of operating service models in other locales is probably penny-pinching and pound-foolish.

6. Share Experience: All states desire access to the experience (good, bad and indifferent) of other jurisdictions. None want to reinvent the wheel. Yet no exchange of "lessons learned" is possible unless the individual states are willing to take the time and be candid enough

to share their successes and failures, triumphs and disasters. While there may be no one best way to approach services for the MII, elements of cost-effective practices can often be adapted to new settings.

C. The Federal Government: The NIMH, the National Institute of Corrections (NIC), and the National Institute of Justice (NIJ), all have important roles to play and activities to undertake.

1. Continue Research: Several interviewees applauded the research, exchange and dissemination activities of the Antisocial and Violent Behavior Branch of the Division of Biometry and Applied Sciences, NIMH. They felt that research should be vigorously continued. If it is increased, several state officials suggested that it be oriented more directly to operational service policy concerns and that the pool of eligible grantees be enlarged to permit broadening of the base of expertise.

2. Collect Data on Forensic Activities: An exploratory survey of forensic activities in the specialized mental health service system is currently under review by the Survey and Reports Branch, NIMH. The results should help establish what the reliability and value of a regular survey might be. It is clear that the absence several years ago of relatively broad national data inhibited an accurate picture of the general dimensions of this problem area.

All the evidence suggests that the institutional, program, policy and patient-flow aspects of the MII problem are changing especially in response to court orders. As a result NIMH should find ways to collect data periodically on the MII.

3. Train Personnel: NIMH could direct greater attention to supporting short-term training of police, jail, prison, and mental health personnel who come in contact with the mentally ill suspect, offender and inmate. Long-term training does not appear indicated. Adding content to existing training programs related to the mentally disordered offender and inmate appears more practical. NIMH could use its role in training to identify and disseminate "better" training materials and practices.

4. Develop Community Support: Community support program development at the local level, especially for the homeless mentally ill, would reduce the likelihood that police would divert them to jails for either public nuisance offenses or for emergency stabilization. Diverting the mentally ill to alternatives to jails is a highly desirable way to reduce the need to deal with them effectively within an incarceration setting.

5. Explore Possible Collaboration with NIC and NIJ: Though interagency relations are beyond the scope of this paper, it seems likely that mutual benefit would accrue from interactive meetings between representatives of the NIMH

and of the National Institute of Corrections. Collaborative workshops for state and local practitioners focused on their priority concerns and joint sponsorship and dissemination of resource materials for state and local agencies are only two of many possible types of useful joint collaboration. Collaborative possibilities and areas of shared interest should also be explored with the National Institute of Justice, especially in the area of empirical research and study.

6. Continue Policy Study and Analysis: This preliminary examination of some of the issues and evidence related to the MII underlines the value and importance of continuing to pursue the development of policy-oriented documents addressed to issues of priority concern and interest to mental health and corrections practitioners and to interested parties in state legislatures, executive policy units and public interest groups. Several of the key subjects addressed in this paper, for example, could be refined, elaborated and expanded for an audience of state and local practitioners. Useful case studies of alternative patterns of mental health/corrections interactions around the MII could and should be developed.

7. Circulate Relevant Documents: Nearly every interviewee felt that problems of the mentally ill inmate deserved greater visibility, publicity and attention. Dissemination of appropriate material to State and local

practitioners and program directors would contribute to broader exposure and understanding of this problem area.

D. Summary: An executive summary of the highlights of this paper appears at the beginning. No additional summary statement is provided.

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## APPENDIX

## INTERVIEWEES

FEDERAL:

Neal Brown, Director, Community Service Systems Branch, Division of Education and Service Systems Liaison, (DESSL) NIMH.

Vernon James, Chief, State Planning and Human Resource Development Branch, DESSL, NIMH.

Thomas Lalley, AVBB, DBAS, NIMH.

Ronald W. Manderscheid, Director, Survey and Reports Branch, Division of Biometry and Applied Sciences, NIMH.

John Moore, National Institute of Corrections.

Ecford Voit, Antisocial and Violent Behavior Branch (AVBB), Division of Biometry and Applied Sciences (DBAS), National Institute of Mental Health (NIMH).

Lindsley Williams, Acting Director, Office of Policy Analysis and Coordination, NIMH.

STATE AND LOCAL:

Lee Roy Black, Associate Professor for Criminal Justice and Vocational Education, California State University.

Steven Hill, Director of Alcohol, Drug Abuse and Mental Health Staff, Florida.

Joel Dvoskin, Director of Forensic Mental Health Services, New York State.

Robert Fein, Director of Forensic Mental Health Services, Massachusetts.

Robert Johnson, Professor of Justice, American University.

Edward Morris, Deputy Director, Adult Institutions, Department of Corrections, Virginia.

Russel Petrella, Director of Forensic Mental Health Services, Virginia.

Roy Praschil, Assistant Director, National Association of State Mental Health Program Directors (NASMHPD).

Barbara Schwartz, Director of Mental Health Services for Central New Mexico Correctional Facility (Los Lunas)

Stuart Silver, Director of Forensic Mental Health Services, Maryland.

Roger Smith, Director, Forensic Psychiatric Program, Oregon State Hospital, Oregon.

## ABOUT THE AUTHOR

Wayne A. Kimmel is a private Human Resources Management Consultant based in Potomac, Maryland. He has spent 26 years (including 5 years with the NIMH and 5 years in the Office of the Assistant Secretary for Planning and Evaluation, HHS) largely in the mental health, health, and social services fields working on policy, program and management problems and issues. He has conducted studies or provided technical assistance in 38 U.S. States and 4 foreign countries. His most recent work has been on strengthening the management of mental health services, preventing youth suicide, improving services to the mentally ill offender and inmate and exploring the role of State government in mental health research.